## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317

To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

May 14, 2012

Mr. Daniel Daly, Administrator Kindred Transitional Care & Rehab Birchwood Terrace 43 Starr Farm Rd. Burlington, VT 05408-1321

Provider #: 475003

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 11, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS

laMCotaRN

Licensing Chief

PC:ne

Enclosure



Apr 25 No. 875335pm P. 4/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/25/2012 FORM APPROVED OMB NO, 0938-0391

| CENTER                   | RS FOR MEDICARE                                                                                                                        | & MEDICAID SERVICES                                                                                                                                                                  |                     |                                                                                                                                                                                                                               | OMB NC                                                               | , 0938-039 <u>1</u> |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------|
| STATEMENT                | OF DEFICIENCIES                                                                                                                        | (X4)-PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER;                                                                                                                                | -{ '                | (X2) MULTIPLE CONSTRUCTION A, BUILDING                                                                                                                                                                                        |                                                                      | SURVEY<br>ETED      |
|                          |                                                                                                                                        | 475003                                                                                                                                                                               | B. WIN              | 3                                                                                                                                                                                                                             | 04/                                                                  | 11/2012             |
| NAME OF P                | ROVIDER OR SUPPLIER                                                                                                                    |                                                                                                                                                                                      |                     | STREET ADDRESS, CITY, STATE, ZIP COD                                                                                                                                                                                          | E                                                                    |                     |
| KINDRE                   | D TRANSITIONAL CA                                                                                                                      | RE & REHAB BIRCHWOOD TER                                                                                                                                                             |                     | 43 STARR FARM RD<br>BURLINGTON, VT 05408                                                                                                                                                                                      |                                                                      |                     |
| (X4) ID<br>PREFIX<br>TAG | EACH DEFICIENCY                                                                                                                        | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)                                                                                                                              | SHOULD BE                                                            | COMPLETION<br>DATE  |
| F 000                    | INITIAL COMMEN                                                                                                                         | тѕ                                                                                                                                                                                   | F 0                 | 00 F 241 A dining plan for residents' # 13                                                                                                                                                                                    | 4, 136, 154,                                                         | May 11, 201         |
| F 2 <b>4</b> 1           | was conducted by<br>i Protection from 04<br>following regulator                                                                        | on-site recertification survey the Division of Licensing and (09/2012 to 04/11/2012. The y deficiencies were identified: Y AND RESPECT OF                                            | F2                  | 171, 148, 115 and 108 80 and 10 established to assure that tablem the same time. Resident #90 ex 4/18/12.                                                                                                                     | ates eat at                                                          |                     |
| SSEE                     | The facility must p manner and in an enhances each res                                                                                 | romote care for residente in a environment that maintains or sident's dignity and respect in his or her individuality,                                                               |                     | The DNS and/or the Nurse Man identify through observation of other residents that may be affect interdisciplinary dining commit established for the benefit of the Special Care Unit. The DNS Manager will educate nursing st | meal service<br>sted. An<br>see has been<br>residents on<br>or Nurse |                     |
|                          | by:                                                                                                                                    | NT is not met as evidenced                                                                                                                                                           |                     | that an appropriate seating plan<br>service is established to maintai<br>resident's dignity during meal s                                                                                                                     | n each                                                               |                     |
| 1                        | facility failed to as                                                                                                                  | sure dignity for residents on lining experience on                                                                                                                                   |                     | The DNS or her designee will e<br>nursing staff on the establishme<br>seating plan for all dining room<br>residents. Nurse managers and                                                                                       | nt of a<br>s that serve                                              |                     |
|                          | at 12:20 PM Residuel                                                                                                                   | at lunch on Unit A on 04/09/12<br>dents #212. #90 and #134 were<br>vith 3 other residents who were<br>at times of 12;30 - 12:50 PM.                                                  | <u> </u>            | nurses will then monitor dining changes that may need to be ma resident need.                                                                                                                                                 | rooms for                                                            |                     |
|                          | The identified resi<br>other residents we<br>residents were no<br>1:40 PM. The state<br>residents stated the<br>for that length of the | dents sat at the table while ere fed and the 3 identified t assisted with eating until 1:30 - f who began feeding these net the residents were waiting time because there was no one |                     | The DNS or her designee will a observation and interview that a seated appropriately in dining reating at the same time as their Results of these audits will be reasonable.                                                  | residents are<br>coms and<br>tablemates.                             | · .                 |
|                          | and # 171 were s                                                                                                                       | for 8 Residents #136, #154, eated with 3 other residents (all                                                                                                                        |                     | monthly PI committee. The responsible for over all comp                                                                                                                                                                       | liance.                                                              | is                  |
|                          | were served from                                                                                                                       | or extensive assistance) who 12:40 PM - 12:55 PM. The 3 s were not septem until 1:45 PM                                                                                              |                     | F241 PDC accepted 5/10/15<br>GCOLEMENEN DMCOTERY                                                                                                                                                                              | J                                                                    | ļ<br>               |
| LABORATO                 | RY DIRECTOR'S OR PRO                                                                                                                   | VIDER SUPPLIES REPRESENTATIVES                                                                                                                                                       | MATURE              | May 3Pd                                                                                                                                                                                                                       | 20                                                                   | (X6) DATE           |

Any deficiency statement ending with an asteriak (\*) denotes a depoint of which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is, requisite to continued program participation.

> If continuation sheet Page 1 of 17 pm

Apr 25 No. 875335pm P. 5/24

|                                          | PRINTED: 04/25/2013 |
|------------------------------------------|---------------------|
| DEPARTMENT OF HEALTH AND HUMAN SERVICES  | FORM APPROVED       |
|                                          | OMB NO. 0938-0391   |
| CENTERS FOR MEDICARE & MEDICAID SERVICES |                     |
| OLIVITEI (ST. OVIVI                      | AM DATE OF DICKEY   |

| STATEMENT OF DEFICIENCIES (X1)-PROVIDED SUPPLIED CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                 |                   | - COMPT |                                                                                  |                                   |                   |
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|                                                                                                                                                        | ROVIDER OR SUPPLIER  TRANSITIONAL CA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | RE & REHAB BIRCHWOOD TER                                                        |                   | 43.5    | TREET ADDRESS, CITY, STATE, ZIP CODE<br>43 STARR FARM RD<br>BURLINGTON, VT 05408 |                                   |                   |
| (X4) ID<br>PREFIX<br>TAG                                                                                                                               | (FACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG | ix      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIENC   | TION SHOULD BE<br>THE APPROPRIATE | CAMPLETION CATE   |
| F 241                                                                                                                                                  | and the staff feeding them stated that there was no staff available to feed these residents any earlier. The residents were still being fed lunch at 2:45 PM.  In another section of the dining room, residents were seated in easy chairs with tray tables. Resident #148 was seated next to a resident who had received a lunch tray. Resident #148 had not received a lunch tray and requested that s/he "have some of that food", pointing to the other resident's tray. She requested food several times and was given a small bowl of potato chips and a glass containing apple juice. S/he continued to request "please can I have some-just a little of that food?". She waited 45 minutes for her tray to arrive and be served to her.  Two other residents (#115 and #108) were witnessed becoming increasingly resides as they awaited meal service while other residents were eating. Resident #115, who walks with a wheeled walker, got up several times and walked without the walker. At one point she was rummaging through a cabinet in the dining room. Resident #105, seated in a restraining chair with a tray, due to falls risk, released his/her tray 3 times while awaiting his/her food tray.  Per observation in room.121 B at 1:40 PM, Resident #80 called out to the passing surveyor asking "can I have a glass or milk or some food." In room 120 B at 1:40 PM, Resident #166 remained in bed where s/he was fed by the Director of Nursing Services who acknowledged that the resident would normally eat In the dining room but s/he had not yet had morning care. |                                                                                 |                   | 241     |                                                                                  |                                   |                   |
|                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                 | 11                | Far     | :ility ID: 475003                                                                | If continuation st                | neet Page 2 of 17 |

FORM CMS-2587(DZ-BB) Previous Versions Obsolete

Fax 8022412348

fipr 25 No. 8753<sub>5pm</sub> P. 6/24

| KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 241 Continued From page 2  Refer also to F353.  F 248 483.15(f)(1) ACTIVITIES MEET  SSEE INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | CENTERS FOR MEDICARE<br>TATEMENT OF DEFICIENCIES<br>ND PLAN OF CORRECTION                                                                                                                                                               | (K4) FROMDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIELE CONSTRUCTION A BUILDING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                     | COMPLETED                                                                                        |                 |  |
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| KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER  (A4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REACH DEPICIENCY MUST BE PRECEDED BY THE RECOUNTRY OR ISC DENTIFYING INFORMATION PAGE  F 241 Continued From page 2 Refer also to F353.  F 246 is 483 1.5(f)(1) ACTIVITIES MEET SS=E INTERESTS/NEEDS OF EACH RES INTERESTS/N |                                                                                                                                                                                                                                         | 475003                                                                                                                                                                                                                                                                                                                                                                                                            | B. WING _                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                     | 04/11/2012                                                                                       |                 |  |
| PREFIX PROJUCTORY OF LIST IDENTIFYING INFORMATION)  F 241 Continued From page 2 Refer also to F353.  F 248 i 483 15(f)(1) ACTIVITIES MEET SS=E INTERESTS/INEEDS OF EACH RES The facility must provide for an engoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation and staff and family interviews, the facility failed to provide an ongoing program of activities designed to meet the the interests and well-being of each resident, based on the comprehensive assessment, the interests and individualized plans of care, for residents of the comprehensive assessment and individualized plans of care, for residents residing or meth especial care Unit Program Director's role has been revised to include weekly designated time to develop meaningful resident specific activities based on resident strengths and preferences.  Current residents will be reassessed to ensure care plans address resident specific activities based on resident strengths and preferences.  Current residents will be reassessed to ensure care plans address resident specific activities based on resident strengths and preferences.  Current residents will be reassessed to ensure care plans address resident specific activities based on resident strengths and preferences.  The Special Care Unit Program Director will condinate activities on the Special Care Unit with the Activity Director and activity assistants.  The Special Care Unit Program Director will condinate activities on the Special Care Unit with the Activity Director and activity assistants.  The Special Care Unit Program Director will condinate activities on the Special Care Unit with the Activity Director and activity assistants.  The Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance.  Falls PDC accepted Titol?                                           | NAME OF PROVIDER OR SUPPLIER                                                                                                                                                                                                            | TRE & REHAB BIRCHWOOD TER                                                                                                                                                                                                                                                                                                                                                                                         | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | DDE                                                                                                                                                                                                                                                                 |                                                                                                  |                 |  |
| Refer also to F353.  Refer also to F353.  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation and staff and family interviews, the facility failed to provide an ongoing program of activities designed to meat the the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation and staff and family interviews, the facility failed to provide an ongoing program of activities dassigned to meat the the interests and well-being of each resident, based on the comprehensive assessment and individualized plans of care, for residents residing on the Special care, for residents residing on the Special care Unit With A.) Findings include:  1. Per observation on 04/09/2012, several residents were seated in the common area of Unit A in the morning, Music was playing in that area and residents were dozing or seated in the room not engaged in an activity. In the afternoon on 04/09/2012 eight residents were observed in the common area with a staff member reading a story. Two residents were awaye and exchanging some conversation with the staff person reading the story at times. A ninth resident was in the area off and on as she wandered in and out of the area while wandering the unit. Other residents with independent mobility came briefly and left throughout the reading.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | PREFIX (EACH DEFICIENC                                                                                                                                                                                                                  | Y MUST BE PRECEDED BY FULL                                                                                                                                                                                                                                                                                                                                                                                        | PREFIX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (EACH CORRECTIVE ACTIO<br>CROSS-REPERENCED TO THE                                                                                                                                                                                                                   | N SHOULD BE                                                                                      | COMPLETION      |  |
| The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by:  Based on observation and staff and family Interviews, the facility failed to provide an ongoing program of activities designed to ment the the interests and well-being of each resident, based on the comprehensive assessment and individualized plans of care, for residents residing on the Special care Unit (Unit A). Findings include:  1. Per observation on 04/09/2012, several residents were seated in the common area of Unit A in the morning, Music was playing in that area and residents were dozing or seated in the common area with a staff member reading a story. Two residents were becoming resitless, while four residents dozed. The remaining two residents were awake and excharging some conversation with the staff person reading the story at times. A ninth resident was in the area while wandering the unit. Other residents with independent mobility came briefly and left throughout the reading.  The facility haprovisions of federal and stats law.  F248  May 11, 201  The Special Care Unit Program Director's role has been revised to include weekly designated time to develop meaningful residents yetling testidents specific activities based on residents strengths and preferences.  Current residents will be reassessed to ensure care plans address resident specific activities based on residents strengths and preferences.  The Special Care Unit Program Director's role has been revised to include weekly designated time to develop meaningful residents well-based on residents strengths and preferences.  The Special Care Unit Program Director will except the Activity Director and activity assistants.  The Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan. Findings will be reported to the monthly Perform | Refer also to F353<br>F 248 (483.15(f)(1) ACTI                                                                                                                                                                                          | 3.<br>VITIES MEET                                                                                                                                                                                                                                                                                                                                                                                                 | F 241 allegation of compliance.  Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                     |                                                                                                  |                 |  |
| designated time to develop meaningful resident specific activities based on or scident's strengths and preferences.  Based on observation and staff and family Interviews, the facility failed to provide an ongoing program of activities designed to meat the the interests and well-being of each resident, based on the comprehensive assessment and individualized plans of care, for residents residing un the Special care Unit (Unit A). Findings include:  1. Per observation on 04/09/2012, several residents were seated in the common area of Unit A in the morning, Music was playing in that area and residents were dozing or seated in the room not engaged in an activity. In the afternoon on 04/09/2012 eight residents were observed in the common area with a staff member reading a story. Two residents were, becoming residess, while four residents were awake and exchanging some conversation with the staff person reading the story at times. A ninth resident was in the area off and on as s/he wandered in and out of the area while wandering the unit. Other residents with independent mobility came briefly and left throughout the reading.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | The facility must portion of activities designed the comprehensive the physical, men                                                                                                                                                    | provide for an ongoing program<br>ned to meet, in accordance with<br>the assessment, the interests and                                                                                                                                                                                                                                                                                                            | sat forth in the statement correction is prepared in the required by the program in the requi |                                                                                                                                                                                                                                                                     | uted solely because ederal and state law.  am Director's                                         | May 11, 2012    |  |
| Include:  1. Per observation on 04/09/2012, several residents were seated in the common area of Unit A in the morning. Music was playing in that area and residents were dozing or seated in the room not engaged in an activity. In the afternoon on 04/09/2012 eight residents were observed in the common area while wandering the unit. Other residents with independent mobility came briefly and left throughout the reading.  The Special Care Unit Program Director will coordinate activities on the Special Care Unit with the Activity Director and activity assistants.  The Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan. Findings will be reported to the monthly Performance Improvement Committee meeting.  The ED is responsible for overall coordinate activities on the Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan. Findings will be reported to the monthly Performance Improvement Committee meeting.  The Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan. Findings will be reported to the monthly Performance Improvement Committee meeting.  The ED is responsible for overall coordinate activities on the Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan.  Findings will be reported to the monthly Performance Improvement Committee meeting.  The ED is responsible for overall compliance.  Falth POC accepted 51/01/2  Government activities on the Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan.  Findings will be reported to the monthly Performance Improvement Committee meeting.  The ED is responsible for overall compliance.                                                                                                                                                                                      | by: Based on observing the factivity of activity on the comprehe                                                                                                                                                                        | vation and staff and family cility failed to provide an ongoing ties designed to meet the the l-being of each resident, based noive assessment and ans of care, for residents residing                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | designated time to develop n resident specific activities be resident's strengths and preferences.  Current residents will be real ensure care plans address resactivities based on resident spreferences.                                                          | neaningful used on erences. essessed to eident specific trengths and                             |                 |  |
| independent mobility came briefly and left throughout the reading.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | on the Special cainclude:  1. Per observation residents were such that in the more and resident room not engage on 04/09/2012 enthe common are story. Two residents were a conversation with story at times. A and on as s/he winclude: | on on 04/09/2012, several eated in the common area of ming. Music was playing in that its were dozing or seated in the ed in an activity. In the afternoon ight residents were observed in a with a staff member reading a ents were becoming restless, into dozed. The remaining two wake and exchanging some in the staff person reading the ninth resident was in the area off wandered in and out of the area |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | coordinate activities on the S Unit with the Activity Direct assistants.  The Special Care Unit Programeet with the DNS and ED months to review the compl Findings will be reported to Performance Improvement of meeting. The ED is responsible for or compliance. | Special Care tor and activity cam Director will weekly times 3 iance plan. the monthly Committee |                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | independent mo                                                                                                                                                                                                                          | bility came briefly and left eading.                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                           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                                                                                            | 661 Page 3 of 1 |  |

THE FNO. 8753- PRINTED: 04/25/2012

FORM APPROVED OMB NO. 0938-0391

| CENTERS                  | FOR MEDICARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | & MEDICAID SERVICES                                                                                                     | +                 |     |                                                                                           | (X3) DATE S                   | IBVEY              |  |
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| YATEMENT C               | OF DEFICIENCIES<br>CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PRÓVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                   | (X2) M            |     | PLE CONSTRUCTION                                                                          | COMPLE                        |                    |  |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 475003                                                                                                                  | B. WING           |     |                                                                                           | 04/1                          | 1/2012             |  |
|                          | ME OF PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                         |                   | 4   | EET ADDRESS, CITY, STATE, ZIP C<br>3 STARR FARM RD                                        | ODE                           |                    |  |
| KINDRED                  | TRANSITIONAL CA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RE & REHAB BIRCHWOOD TER                                                                                                |                   | B   | URLINGTON, VT 05408                                                                       |                               | · ·                |  |
| (X4) ID<br>PREFIX<br>TAG | ISACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                          | ID<br>PREF<br>TAC |     | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY | IN SHOULD BE<br>E APPROPRIATE | COMPLETION<br>DATE |  |
| F 248                    | Continued From page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | age 3                                                                                                                   | F                 | 248 |                                                                                           |                               |                    |  |
| i                        | In conversation, one family member asked to speak with a surveyor, wishing to remain anonymous. S/he stated that the activity program was not what was posted on the wall. S/he stated that the residents were often just sitting with music or the TV playing and that the exercise and other engaging activities had not happened for several months. This family member added that in the second and third day of survey more activities than usual occurred on Unit A. In a family interview, conducted in Stage I of the survey, a family member stated that, usually the activity was simply music playing on the unit who residents sat in the common room. S/he stated that frequently there was no staff present in the room to monitor and/or assist residents during this time. In a staff interview the Unit Program director confirmed that the number of hours perweek for activities staff had been recently reduced by the corporate office.  In a review of Unit A activities, there are two activity schedules posted on the wall of the common room, The first is a schedule of the data called "Birchwood Terrace Healthcare-Special Care Unit Here's what we do each day!" This lincludes Rise and Shine (AM Care by LNA's), Musical Chairs (moving residents to their chair fer lunch while music plays), Cafe. Birchwood (lunch) and Supper Club (dinner) a dining ground of 8 residents who go to the Main Dining Room for these meals, Blissful Relaxation (afternoon naps in beds or resting in chairs), and Good |                                                                                                                         |                   |     |                                                                                           |                               |                    |  |
| ·                        | Afternoon Snack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ernoon at the Terrace (AM and s in the common area or resident c playing in the common area). ctivities such as sensory |                   |     |                                                                                           |                               |                    |  |
| L                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | - ID                                                                                                                    |                   |     | Egolifer ID: 475003                                                                       | If continuation sh            | eet Page 4         |  |

קאר 44No. 8753יישיגייף. 8/24' PRINTED: 04/25/2012

|                          |                                | AND HUMAN SERVICES                                                              |                   |      |                                                                                         |             | 1 APPROVED<br>), 0938-0 <u>391</u> |
|--------------------------|--------------------------------|---------------------------------------------------------------------------------|-------------------|------|-----------------------------------------------------------------------------------------|-------------|------------------------------------|
| CENTER                   | S FOR MEDICARE                 | & MEDICAID SERVICES                                                             | <del></del>       |      |                                                                                         |             |                                    |
| TATEMENT<br>ND PLAN O    | of Deficiencies<br>Foorraction | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;                              | (X2) M            |      | TIPLE CONSTRUCTION NG                                                                   | (X3) DATE S |                                    |
|                          |                                | 475003                                                                          | B. WING C4/       |      |                                                                                         |             | 11/2012                            |
| NAME OF P                | ROVIDER OF SUPPLIER            |                                                                                 |                   | ST   | TREET ADDRESS, CITY, STATE, ZIP COD                                                     | €           |                                    |
|                          |                                |                                                                                 |                   | ١.   | 43 STARR FARM RD                                                                        |             |                                    |
| KINDRED                  | TRANSITIONAL CA                | RE & REHAB BIRCHWOOD TER                                                        |                   |      | BURLINGTON, VT 05408                                                                    |             |                                    |
| (XA) ID<br>PREPIX<br>TAG | /EACH DEFICIENC                | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG | ΊX   | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE   | (X5)<br>COMPLETION<br>DATE         |
|                          |                                | 1                                                                               |                   |      | <u> </u>                                                                                |             | 1                                  |
| F 248                    | Continued From pa              | age 4                                                                           | F                 | 248  | 8                                                                                       |             |                                    |
| , ,,,,                   |                                | stretch, words and music,                                                       |                   |      |                                                                                         |             | 1                                  |
| •                        | dame time and 80               | othing the senses listed. After                                                 |                   |      |                                                                                         |             | 1                                  |
|                          | dinner activities in           | clude Memories of the Small                                                     |                   |      |                                                                                         |             | 1                                  |
|                          | Screen (television             | with old TV shows                                                               |                   |      | l                                                                                       |             | 1                                  |
| i                        | (reminiscing) or m             | usic) and Enchanted Evening                                                     |                   |      |                                                                                         |             | 1                                  |
|                          | (HS care and a mo              | ovie for those who care to                                                      |                   |      |                                                                                         |             | !                                  |
|                          | watch). This was o             | confirmed in an interview with                                                  |                   |      |                                                                                         |             |                                    |
|                          | the Unit Program I             | Director on 04/11/2012 at 4:30                                                  |                   |      |                                                                                         |             | ;                                  |
|                          | PM.                            | -                                                                               |                   |      |                                                                                         |             | i                                  |
|                          | La rejuition listadusis        | the monthly schedule include                                                    |                   |      | 1                                                                                       |             | İ                                  |
|                          | Activities listed on           | Dining Room (attended by 2                                                      |                   |      |                                                                                         |             | 1                                  |
|                          | I Init A regidents)            | Saturdays include alternating                                                   |                   |      |                                                                                         |             | į                                  |
|                          | Arts & Crafts and              | Ice Cream Social. In interview                                                  |                   |      |                                                                                         |             | !                                  |
|                          | the Program Direct             | tor states that the Arts & Crafts                                               |                   |      | . •                                                                                     |             | :                                  |
|                          | is primarily colorin           | g, while staff states that on                                                   |                   |      |                                                                                         |             | i '                                |
|                          | occasion some re               | sidents do scrapbooking. The                                                    |                   |      | •                                                                                       |             | ļ                                  |
|                          | lice cream social is           | s residents gathered in the                                                     |                   |      | i                                                                                       |             |                                    |
|                          | common areas fo                | r ice cream and "socializing".                                                  |                   |      |                                                                                         |             |                                    |
|                          | Each day on this               | monthly schedule lists two                                                      | _                 |      |                                                                                         |             |                                    |
|                          | activities (which in           | nclude Bingo attended by two                                                    |                   |      | ·                                                                                       |             |                                    |
| 1                        | residents off unit             | A each Friday and occasional                                                    |                   |      | :                                                                                       |             |                                    |
| }                        | Saturdays) and vi              | sits by the facility hairdresser on the unit by activities staff)               |                   |      |                                                                                         |             | į                                  |
|                          | : (MUO IS SESISTED (           | not all residents are involved in                                               |                   |      |                                                                                         |             | į                                  |
|                          | hair dregger visits            | ). On three days in March and                                                   |                   |      |                                                                                         |             | 4                                  |
|                          | three days in Apri             | I there are music activities in the                                             |                   |      |                                                                                         |             | Į.                                 |
|                          | main dining room               | attended by "as many residents                                                  |                   |      |                                                                                         |             |                                    |
|                          | as possible" from              | . A Unit according to the program                                               |                   |      |                                                                                         |             |                                    |
|                          | director, S/he sta             | ted that although they would like                                               |                   |      |                                                                                         |             |                                    |
| <u> </u>                 | to have special m              | nusic presentations for Unit A                                                  | ,                 |      | i                                                                                       |             | <u> </u>                           |
| }                        | this was not finan             | cially feasible. "We need to get                                                | ļ .               |      | 1                                                                                       |             |                                    |
|                          | the most bang fo               |                                                                                 |                   | F 27 | 79                                                                                      |             | 1                                  |
| 1                        | 483.20(d), 483.20              | J(K)(T) DEVELOR                                                                 | į '               |      |                                                                                         |             |                                    |
| ss=0                     | COMPREHENS                     | VE CARE PLANS                                                                   |                   |      | •                                                                                       |             |                                    |
|                          | A familia, much un             | e the results of the assessment                                                 |                   |      |                                                                                         |             | }                                  |
| 1                        | to develop revies              | w and revise the resident's                                                     |                   |      | •                                                                                       |             | {                                  |
| 1                        | TO GOADION' LGAIC.             |                                                                                 | 1                 |      | ;                                                                                       |             |                                    |

FORM CMS-2667(02-99) Previous Versions Obsolete

Event ID: 4NFK11

Facility ID: 475003

If continuation sheet Page 5 of 17

Fax 3022412348

Apr 25 No. 875336pm P. 9/24,

| ACMITED                  | S EOR MEDICARE                                                               | & MEDIÇAID SERVICES                                                                                                                  |                                       |                                                  |                                                                                                                                                                                                                   |                                                        | 0938-0391          |
|--------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------|
| ATEINENT                 | OF DEFICIENCIES<br>F CORRECTION                                              | (X1)-PROVIDER/SUPPLIEP/CLIA IDENTIFICATION NUMBER:                                                                                   | 1' '                                  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |                                                                                                                                                                                                                   | (X3) DATE S                                            |                    |
| - <del>-</del>           |                                                                              | 475003                                                                                                                               | 1                                     |                                                  |                                                                                                                                                                                                                   | 04/11/2012                                             |                    |
| IAME OF P                | ROVIDER OR SUPPLIER                                                          |                                                                                                                                      | ~.l                                   |                                                  | EET ADDRESS, CITY, STATE, ZIP COD                                                                                                                                                                                 | E                                                      | •                  |
| KINDRE                   | TRANSITIONAL CA                                                              | RE & REHAB BIRCHWOOD TER                                                                                                             |                                       |                                                  | STARR FARM RD<br>URLINGTON, VT 05408                                                                                                                                                                              |                                                        |                    |
| (X4) ID<br>PREFIX<br>TAG | (FACH ORFICIENC)                                                             | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                 | ID<br>PREF<br>TAG                     |                                                  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)                                                                                                                     | SHOULD BE                                              | COMPLETION DATE    |
| F 279                    | Continued From pa                                                            |                                                                                                                                      | F                                     | 279                                              | This Plan of Correction is the center's allegation of compliance.                                                                                                                                                 | credible                                               |                    |
|                          | comprehensive pla                                                            | an of care.                                                                                                                          |                                       |                                                  | Preparation and/or execution of this p                                                                                                                                                                            |                                                        |                    |
|                          | plan for each reside objectives and time medical, nursing, a                 | evelop a comprehensive care lent that includes measurable etables to meet a resident's and psychosocial ntifled in the comprehensive | does not provided set forth correctly |                                                  | does not constitute admission or agree provider of the truth of the facts allege set forth in the statement of deficiencie correction is prepared and/or executed it is required by the provisions of feder P 279 | d or conclusions<br>s. The plan of<br>i solely because | <b>May</b> 11, 201 |
|                          | to be furnished to<br>highest practicable<br>psychosocial well-              | st describe the services that are attain or maintain the resident's e physical, mental, and being as required under                  |                                       |                                                  | Resident # 144 care plan was up reflect use of clip alarm to alert resident's attempts to transfer wassistance.                                                                                                   | staff of                                               |                    |
|                          | be required under<br>due to the resider                                      | services that would otherwise \$483.25 but are not provided at sexercise of rights under the right to refuse treatment (4).          |                                       |                                                  | Current residents assessed to be<br>for falls will be reviewed for ca<br>interventions. Care plans will be<br>for any resident without a care                                                                     | re plan<br>se developed<br>plan.                       |                    |
|                          | This REQUIREM                                                                | ENT is not met as evidenced                                                                                                          |                                       |                                                  | The DNS or her designee will e<br>on the care plan process for fall                                                                                                                                               |                                                        |                    |
|                          | by: Based on clinical the facility failed to                                 | record review and Interview,<br>o develop a comprehensive plan<br>ded fall interventions initiated at                                | i.                                    |                                                  | Audits (record review) of resid-<br>risk for falls will be conducted<br>plan of care is in place.                                                                                                                 |                                                        |                    |
|                          | the time of admis<br>assessed to be a<br>one (#144) of 17<br>comprehensive p | ision for one Resident (#144) t high risk for falls. This affected Resident records reviewed for lans of care. Findings include:     |                                       |                                                  | Results of these audits will be a<br>monthly PI committee and char<br>done as needed. The DNS is re<br>overall compliance.                                                                                        | nges will be                                           | ,                  |
|                          | Per clinical record                                                          | d review on 04/10/12, Resident ed on 01/21/12 with a non                                                                             |                                       |                                                  |                                                                                                                                                                                                                   |                                                        |                    |
|                          | operable femoral sustained in a fall Review of the Pa                        | neck fracture (broken hip)<br>If prior to admission to the facility<br>Itient Nursing Assessment of the                              | •                                     |                                                  | F279 POC accepted 5/1<br>G. Coleman RNI OMCOto                                                                                                                                                                    | olia<br>Len                                            |                    |
|                          | score of 70 (45 s                                                            | led a Morse Fall Risk Scale<br>and higher indicates high fall<br>the Bed Safety Evaluation dated                                     |                                       |                                                  |                                                                                                                                                                                                                   |                                                        |                    |

Fax 8D22412348

Apr 25 No. 8753 Gpm P. 10/24

PRINTED: 04/25/2012 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XX) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING **B. WING** 04/11/2012 475003 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVICER OR SUPPLIER 43 STARR FARM RD KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER BURLINGTON, VT 05408 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION io SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 279 F 279 Continued From page 6 1/21/12 and the Treatment Records for January through March 2012, revealed no indication of the use of an alarm. Review of the Resident Progress Notes dated 1/21/12 at 10:35 P.M. revealed that a clip alarm was in place. The Progress Notes periodically mention the use of a clip alarm to alert staff to the Residents attempts to transfer without assistance between 1/21/12 and 3/31/12. On 3/12/12 at 9:00 A.M. an Event Assessment indicated that Resident #144 was observed kneeling in front of a chair with no clip alarm in place. The Plan of Care for falls, dated 02/03/12, indicated Resident #144 had a fall prior to admission with a right hip fracture, used medications that affected fall risks and used a wheelchair. The Plan of Care indicated that Resident #144 had a fall on 3/12/12 and slid out a chair secondary to having no olle alarm in place. Interview of the Registered Nurse, Unit Manager on 04/10/12 at 4:45 P.M. revealed that an alarm was initiated on 01/21/12, as a result of the fall . risk assessment score, but was not written on the triplicate form and as a result, was not flowed on the Treatment Record for the nurses to track, or noted on the comprehensive Plan of Care for i falls. On 4/11/12, at 8:40 A.M., the RN, unit manager stated that a clip alarm had been used since admission and should have been tracked by the nurses on the treatment record and should have been reflected on the plan of care. S/he verified that the Plan of care did not comprehensively reflect the interventions in place since admission and was not updated on 03/12/12, when a fall

FORM CM\$-2557 (02-99) Previous Versions Obsolete

Event ID: 4NFK11

Facility ID: 475003

If continuation sheet Page 7 of 17

Fax 8022412348

FIFT 25No. 875336pmP. 11/24

PRINTED: 04/25/2012

FORM APPROVED OMB NO. 0938-0391

| DEL VIVI                 | S EOR MEDICARE                                                                                                                                                                                                                                                                                                 | & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                    |                   |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OMB NO.                                                                                                   | 938-0391                      |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------|
|                          |                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE     |     | LE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (XS) DATE SUF                                                                                             |                               |
| HAIEMEN                  | OF DEFICIENCIES TO<br>F CORRECTION                                                                                                                                                                                                                                                                             | IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                 | A BUIL            |     | -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | GOMPLETED                                                                                                 |                               |
|                          |                                                                                                                                                                                                                                                                                                                | 475003                                                                                                                                                                                                                                                                                                                 | B. WIN            | ie  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 04/11                                                                                                     | /2012                         |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                            | RE & REHAB BIRCHWOOD TER                                                                                                                                                                                                                                                                                               |                   | 43  | ET ADDRESS. CITY, STATE, ZIP CODE<br>STARR FARM RD<br>JRLINGTON, VT 05408                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                               |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY ST.                                                                                                                                                                                                                                                                                                    | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                        | ID<br>PREF<br>TAG | ıx  | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATIO | ULO BE                                                                                                    | (XB)<br>COMPLETION ""<br>DATE |
| F 323                    | 483.25(h) FREE C<br>HAZARDS/SUPER<br>The facility must environment remains is possible; and                                                                                                                                                                                                                    | he alarm intervention in place, OF ACCIDENT RVISION/DEVICES Insure that the resident Ins as free of accident hazards It each resident receives It each assistance devices to                                                                                                                                           |                   | 323 | This Plan of Correction is the center's creatlegation of compliance.  Preparation and/or execusion of this plan does not constitute admission or agreeme provider of the truth of the facts alleged a set forth in the statement of deficiencies, correction is prepared and/or executed so it is required by the provisions of federal  F 323  Resident # 144 care plan was upd reflect use of clip alarm to alert st resident's attempts to transfer wit assistance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | of correction nt by the nt by the reconclusions The plan of slely because and state law, ated to aff of   | May 11, 201                   |
|                          | by: Based on clinical the facility failed to intervention for or high risk for fails fracture. This affixampled Resider accidents. Finding Per clinical recommendation operable femoral sustained in a fall Review of the Pasame date revea score of 70 (45 a risk). Review of 1/21/12 and the through March 2 | d review on 04/10/12, Resident ed on 01/21/12 with a non neck fracture (broken hip). I prior to admission to the facility trient Nursing Assessment of the led a Morse Fall Risk Scale and higher Indicates high fall the Bed Safety Evaluation dated Treatment Records for January 012, revealed no indication of the |                   |     | Current residents assessed to be a for falls will be reviewed for care interventions. Care plans will be for any resident without a care plan process for fall plans of care plan process for fall plans of care is in place.  Results of these audits will be remonthly PI committee and chang done as needed. The DNS is resoverall compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | plan developed an.  ucate staff revention  ats with high ensure a  ported to the ges will be ponsible for |                               |
|                          | use of an alarm. Progress Notes revealed that a c                                                                                                                                                                                                                                                              | Review of the Resident dated 1/21/12 at 10:35 P.M. lip alarm was in place. The periodically mention the use of a t staff to the Residents attempts                                                                                                                                                                     |                   |     | F323 POC accepted 5/10/16<br>GColeman RN/ PMCotaRN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           |                               |
| EDBW CMS                 |                                                                                                                                                                                                                                                                                                                | ions Obsolete Event IO: 4NF                                                                                                                                                                                                                                                                                            | (11               | F   | acility ID: 475003                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ontinuation she                                                                                           | et Page 8 of 17               |

Apr 25 No. 8753 Epm P. 12/24

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION

|                          | OF DEFICIENCIES<br>F CORRECTION                                                                                                                                                                                                                                                                                            | (141) PROVIDER/SUPPLIER/CUA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |                                                                                           |                              | (X3) DATE SURVEY           |  |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-------------------------------------------------------------------------------------------|------------------------------|----------------------------|--|
|                          | 475003 B. WING                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | · · · · · · · · · · · · · · · · · · ·                                                     | 04/11/2012                   |                            |  |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                        | ARE & REHAB BIRCHWOOD TER                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 43                  | REET ADDRESS, CITY, STATE, ZIP CI<br>3 STARR FARM RD<br>BURLINGTON, VT 05408              | ODE                          |                            |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                            | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                           | IO<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (%5)<br>COMPLETION<br>OATE |  |
| F 323                    |                                                                                                                                                                                                                                                                                                                            | age 8 assistance between 01/21/12                                                                                                                                                                                                                                                                                                                                                                                                                                                          | F 323               |                                                                                           |                              |                            |  |
|                          | On 3/13/12 an Ev<br>Resident #144 we<br>a chair with no cli<br>Care dated 02/03<br>had a fall prior to<br>fracture and used<br>indicated that Red<br>03/12/12 and had<br>having no clip ala<br>report dated 03/1<br>fracture resulted,<br>bearing from 8:30<br>P.M. on 03/13/12<br>resumed, per phy<br>indication that Red | ent Assessment indicated that is observed kneeling in front of or alarm in place. The Plan of 1/12, indicated Resident #1/44 admission with a right hip a walker. The Plan of Caresident #1/44 had a fall on slid out a chair secondary to rm in place. A mobile X-ray 2/12 indicated a left pelvic Resident #1/44 was non weight 1/12. P.M. on 03/12/12 until 12:20 when therapy treatment was resician's orders. There was no sident #1/44 had a significant in related to the fracture. |                     |                                                                                           |                              |                            |  |
| <b>.</b> .               | Manager on 04/1 clip alarm was in written on the trip not flowed on the nurses to track o Plan of Care for the RN, unit man been used since been tracked by record and should                                                                                                                                              | legistered Nurse (RN), Unit 0/12 at 4:45 P.M. revealed that a tiated on 01/21/12 but was not licate form and, as a result, was Treatment Record for the noted on the comprehensive falls. On 4/11/12, at 8:40 A.M. ager stated that the alarm had admission and should have the nurses on the treatment d have been reflected on the                                                                                                                                                       |                     |                                                                                           |                              |                            |  |
| F 353                    | in place at the thr<br>should have bee<br>documented atte<br>assistance. S/he<br>sustained as a re                                                                                                                                                                                                                         | e verified that the alarm was not ne of the fall on 03/12/12 and in place due to frequently mpts to transfer without everified a pelvic fracture was esult.  CIENT 24-HR NURSING STAFF                                                                                                                                                                                                                                                                                                     | F 353               | 3                                                                                         |                              |                            |  |

FORM CMS-2567(02-98) Previous Versions Obsolo(&

Event ID: 4NFK11

Facility ID: 475003

If continuation sheet Page 9 of 17

Fax 8022412348

при 25 No. 8753<sub>Ійря</sub> Р. 13/24

| CENTER                                                   | S FOR MEDICARE                                                                  | & MEDICAID SERVICES                                                                                                                                         |                     |                 |                                                                                                                                                                                                                                                                                        | <del></del>                                               | <u>. 0936-0391</u> |
|----------------------------------------------------------|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------|
| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) |                                                                                 | 1'                                                                                                                                                          |                     | LE CONSTRUCTION | (X3) DATE SURVEY                                                                                                                                                                                                                                                                       |                                                           |                    |
| NO PLAN O                                                | FOURKECTION                                                                     | IDENTIFICATION NO.                                                                                                                                          | A, BUILI            | DINO            |                                                                                                                                                                                                                                                                                        | '                                                         |                    |
|                                                          |                                                                                 | 475003                                                                                                                                                      | e. WING             | 3               | <del></del>                                                                                                                                                                                                                                                                            | 04/11/2012                                                |                    |
| NAME OF P                                                | ROVIDER OR SUPPLIER                                                             |                                                                                                                                                             |                     | STRE            | ET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                      |                                                           |                    |
|                                                          |                                                                                 | RE & REHAB BIRCHWOOD TER                                                                                                                                    |                     |                 | STARR FARM RD<br>IRLINGTON, VT 05408                                                                                                                                                                                                                                                   |                                                           |                    |
|                                                          |                                                                                 |                                                                                                                                                             |                     | -               |                                                                                                                                                                                                                                                                                        | TION                                                      | 176)               |
| (X4) IO<br>PREFIX<br>TAG                                 | (FACH DEFICIENC)                                                                | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                               | IO<br>PREFIX<br>TAG | <b>(</b>        | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)                                                                                                                                                                                | ULD BE                                                    | COMPLETION<br>DATE |
|                                                          |                                                                                 |                                                                                                                                                             |                     | -               |                                                                                                                                                                                                                                                                                        |                                                           |                    |
|                                                          | Continued From pa                                                               | ı                                                                                                                                                           | F 3                 |                 | This Plan of Correction is the center's credit                                                                                                                                                                                                                                         | ole                                                       |                    |
| SS=E                                                     | PER CARE PLANS                                                                  | 5                                                                                                                                                           |                     |                 | allegation of compliance.                                                                                                                                                                                                                                                              |                                                           |                    |
|                                                          | provide nursing an<br>maintain the highe<br>and psychosocial v                  | ave sufficient nursing staff to direlated services to attain or st practicable physical, mental, well-being of each resident, as dent assessments and care. |                     |                 | Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. To correction is prepared and/or executed sole it is required by the provisions of federal and F 353 | conclusions<br>ne plan of<br>nly because<br>nd state law. | May 11, 201        |
|                                                          | •                                                                               |                                                                                                                                                             |                     |                 | •                                                                                                                                                                                                                                                                                      | _                                                         |                    |
|                                                          | numbers of each of personnel on a 24                                            | rovide services by sufficient of the following types of hour basis to provide nursing is in accordance with resident                                        |                     | :               | Residents # 212, 134, 154, 171, 14<br>108, 80, 136 and 166 have been re-<br>to ensure they receive their meals i<br>manner. Resident #90 expired 4/1                                                                                                                                   | in a timely<br>8/12.                                      |                    |
|                                                          | section, licensed repersonnel.                                                  | ed under paragraph (c) of this<br>nurses and other nursing                                                                                                  |                     |                 | The process for delivering persons<br>timely meals and meaningful resid<br>specific activities has been revised<br>the needs of the residents on the S                                                                                                                                 | i co meel                                                 |                    |
|                                                          | section, the facility                                                           | red under paragraph (c) of this y must designate a licensed a charge nurse on each tour of                                                                  | ;                   |                 | Care Unit.  The Special Care Unit Program I Special Care Unit Manager will cefforts to ensure the revised, struprocess is implemented and main                                                                                                                                         | ctured                                                    | 1                  |
|                                                          | by: Based on observe facility failed to as nursing and relate highest practicab | ENT is not met as evidenced ration and staff interviews, the source sufficient staff to provide ad services to maintain the le well-being of each resident  |                     |                 | The DNS will meet with the SCI Director and SCU Nurse Manag times 3 months to review compl plan. Findings will be reported committee monthly x3 months.                                                                                                                                | U Program<br>er weekly<br>iance with                      |                    |
|                                                          | plans of care. Fin                                                              |                                                                                                                                                             |                     |                 | The ED is responsible for overa compliance.                                                                                                                                                                                                                                            |                                                           | :                  |
|                                                          | at 12:20 PM Resi                                                                | n at lunch on Unit A on 04/09/12<br>dents #212, #90 and #134 were<br>with 3 other residents who were<br>at times of 12:30 - 12:50 PM                        |                     |                 | F353 POC accepted 5/10/17<br>GColeman RN/ OPN cotaPN                                                                                                                                                                                                                                   | <b>)</b> —                                                |                    |
|                                                          |                                                                                 | and the same                                                                                                                                                |                     |                 | Printer No. 47.5003                                                                                                                                                                                                                                                                    | tinuation she                                             | et Page 10 of      |

| CENTERS FOR MEDICARE & MEDICAID SERVICES |                                                                                                                                                                            |                                                                                                                                                   |                                                                                               |                    | OMB NO. 09 |                                |                                                                     |                                             |                            |  |
|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------|------------|--------------------------------|---------------------------------------------------------------------|---------------------------------------------|----------------------------|--|
| TATEMENT                                 | OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                           | (X1) PROVIDER/SUPPL                                                                                                                               | JERUCLIA (                                                                                    | (X2) M<br>A. BUII  |            | LE CONSTRUCTION                | J                                                                   | (X3) DATE SURVEY<br>GOMPLETED<br>04/11/2012 |                            |  |
|                                          |                                                                                                                                                                            | 47500                                                                                                                                             |                                                                                               | B. WIN             |            |                                |                                                                     |                                             |                            |  |
| NAME OF P                                | ROMDER OR SUPPLIER                                                                                                                                                         |                                                                                                                                                   |                                                                                               |                    | STRE       | ET ADDRESS, CIT                | Y. STATE, ZIP COD                                                   |                                             |                            |  |
| ·                                        | D TRANSITIONAL CA                                                                                                                                                          | RE & REHAB BIRCI                                                                                                                                  | HWOOD TER                                                                                     | .                  | 43         | STARR FARM RU<br>URLINGTON, VI | )                                                                   | •                                           |                            |  |
| (X4) ID<br>PREFIX<br>TAG                 | (EACH DEFICIENCY                                                                                                                                                           | TEMENT OF DEFICIENCY MUST BE PRECEDED IN SCIDENTIFYING INFOR                                                                                      | BY FULL                                                                                       | ID<br>PREFI<br>TAG |            | (EACH COR                      | R'S PLAN OF COR<br>RECTIVE ACTION<br>RENCED TO THE A<br>DEFICIENCY) | SHOULD BE                                   | (XS)<br>COMPLETION<br>DATE |  |
| F 353                                    | Continued From pa                                                                                                                                                          | ige 10                                                                                                                                            |                                                                                               | F                  | 353        |                                |                                                                     | •                                           |                            |  |
|                                          | The identified residents were residents were not 1:40 PM. The staff residents stated the for that length of tir available to feed the                                      | ents sat at the table re fed and the 3 lde assisted with eating who began feeding at the residents we ne because there we                         | ntified<br>g until 1:30 -<br>g these<br>re waiting                                            |                    |            |                                |                                                                     | •                                           |                            |  |
|                                          | At a second table if and # 171 were se requiring feeding of were served from Identified residents and the staff feeding no staff available to earlier. The reside 2:45 PM. | ated with 3 other re<br>r extensive assista<br>12:40 PM - 12:55 P<br>s were not served u<br>ng them stated that<br>o feed these reside            | esidents (all nce) who M. The 3 ntil 1:45 PM there was ente any                               |                    |            |                                |                                                                     |                                             |                            |  |
|                                          | In another section                                                                                                                                                         | of the dining room,<br>ay chairs with tray to                                                                                                     | residents                                                                                     |                    |            |                                |                                                                     |                                             | ;                          |  |
|                                          | Resident #148 was had received a lunch to received a lunch to "have some of that resident's tray. She and was given a siglass containing a request "please care."          | s seated next to a rich tray. Resident # ray and requested to tood", pointing to a requested food simall bowl of potato pple juice. S/he college. | resident who in the side of the other everal times end a intinued to the interest a little of |                    |            |                                |                                                                     |                                             |                            |  |
| P                                        | arrive and be serv                                                                                                                                                         |                                                                                                                                                   |                                                                                               |                    |            |                                |                                                                     | •                                           |                            |  |
|                                          | witnessed becoming awaited meal serving. Resident # walker, got up sevithe walker. At one                                                                                  | ts (#115 and #108) ng increasingly res ice while other resi 115, who walks with rerel times and wall point she was rum in the dining room.        | tless as they dents were the wheeled ked without imaging                                      | -                  |            | ·                              |                                                                     |                                             |                            |  |
| FORM CMS-                                | -2867(02-99) Pravious Veralo                                                                                                                                               | ne Obsolate                                                                                                                                       | Event ID: 4NFK11                                                                              |                    | FB         | cllity ID: 475003              | lf :                                                                | continuation she                            | et Page 11 pf 17           |  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

No. 8753 - JUPP P. 15/24

| PRINTED: 04/25/2012 |
|---------------------|
| FORM APPROVED       |
| OMB NO. 0938-0391   |

|   |                          | OF DEFICIENCIES OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIP<br>IOENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ' '                                                                                    | MULTIP!<br>HLDING | É CONSTRUCTION                                                              | (X3) DATE E          |                            |
|---|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------|-----------------------------------------------------------------------------|----------------------|----------------------------|
|   |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 478003                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ø, w                                                                                   | NG                |                                                                             | 04/                  | 11/2012                    |
| _ |                          | ROVIDER OR SUPFUER<br>D TRANSITIONAL C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ARE & REHAB BIRCHWOOL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | D TER                                                                                  | 43 5              | ET ADDRESS, CITY, STATE, Z<br>STARR FARM RD<br>RLINGTON, VT 05408           | IP CODE              |                            |
|   | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREI<br>YA                                                                       | FIΧ               | PROVIDER'S PLAN O<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIEN | THE APPROPRIATE      | (XS)<br>COMPLETION<br>DAYE |
|   | F 353                    | to falls risk, release awaiting his/her for exident #80 call asking "can I have In room 120 B at remained in bed with that the resident room but s/he have room but s/he release room servation. The for several minute attention to the room but s/he room servation. Resident same lunch so chair sawaiting lur 1:05 PM the Resident single room safety tray, the surveyur record. The first tray, the surveyur service in the surveyur surveyur services in the surveyur surveyur services in the surveyur services as | restraining chair with a tray and his/her tray 3 times while and tray.  In room 121 B at 1:40 PM, and out to the passing surve a glass of milk or some for 1:40 PM, Resident #166 where s/he was fed by the ag Services who acknowled would normally eat in the did not yet had moming care.  Ins on 04/09/12 at 12:40 PM # 115 was observed walking and rummaging through a cord review, Resident #115 where and rummaging through a cord review, Resident #115 where and for use of a walker where suntil the surveyor called assident. During the same president #108 was observed to have restraining tray, which was no prevent falls according to time s/he loosened the restrictive when he began leaning utes when he began leaning utes when he began leaning tray which was when he began leaning utes when he began leaning tray which was tray when he began leaning tray which was when he began leaning tray which was tray when tray which was tray when | yor pod?"  ged ning sis a ff to valker staff eriod d at raint nd the traint the traint | 353:              |                                                                             |                      |                            |
|   |                          | with the Unit Mar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | the residents during an intentager on 04/11/12, on Unit<br>there are 50 residents.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | A (the                                                                                 | j                 |                                                                             |                      |                            |
|   | FORM CMS.                | .2567(02-99) Previous Vers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | lans Obsolete Event I                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | D:4NFK11                                                                               | Faci              | iity ID: 475003                                                             | If continuation shee | et Page 12 of 1            |

PRINTED: 04/25/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B WING 475003 04/11/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 43 STARR FARM RD KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER BURLINGTON, VT 05408 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ΙD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE FPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG . DEFICIENCY F 353 F 353 Continued From page 12 those 50 residents, 6 residents require total care, total assistance with eating, and require transfer . via a Hoyer Lift. 14 residents require total care, total assistance with eating, and a transfer assist of 1 or 2. An additional 10 residents require total care and some assistance or monitoring with eating and transfers. The remaining residents on the unit all require some level of assistance or supervision in some or all aspects of care and a number of the entire unit census experience resistance to care at some level. In summary, 30 residents require total care for hygiene and grooming and all residents require care and monitoring. According to the Unit Manager staffing is usually 5 LNAs (Licensed Nursing Assistants) however there are frequent days when there are call-ins or only 4 LNAs to care for the residents. Nurses may be pulled to caregiver positions to assist in providing direct care. in a review of the provided schedule dated March 2, 2012 to March 29, 2012 there were 6 LNAs assigned to Unit A on only 1 day, there were 5 LNAs assigned on 5 days, 4 LNAs assigned on 15 days, 3 LNAs assigned on 5 days and 2 LNAs assigned on 2 days to care for 50 Special Care Unit residents. On all days, except the 2nd, 3rd, 27th and 28th of March, there were additional shifts scheduled ranging in length of time and combination; however, 9 of these were one 2 hour additional shift. (Where two partial shifts comprised a whole 6:30 to 2:30 shift, or other straight 8 hours, the number of staff above was adjusted.) Refer also to F9999. F 356 1483,30(e) POSTED NURSE STAFFING F 356 SS=C: INFORMATION If continuation sheet Page 13 of 17 Event ID; 4NFK11 Peckiny ID: 475003 FORM CMS-2887(02-99) Previous Versions Obsolete

Apr 25No. 875337pm P. 17/24

PRINTED: 04/25/2012 FORM APPROVED

|                          |                                                                                                              | AND HUMAN SERVICES                                                                                                                                        |                     |                                                                                                                                                                                                                                |                                                                                      | APPROVED<br>0, 0938-0391   |
|--------------------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------|
|                          |                                                                                                              | & MEDICAID SERVICES                                                                                                                                       | (Y2) MILLT          | PLE CONSTRUCTION                                                                                                                                                                                                               | (X3) DATE 8                                                                          |                            |
| TATEMENT<br>IND PLAN OF  | OR DEFICIENCIES<br>CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                     | A BUILDIN           |                                                                                                                                                                                                                                | COMPL                                                                                |                            |
|                          |                                                                                                              | 475003                                                                                                                                                    | B, WING_            |                                                                                                                                                                                                                                | 04/                                                                                  | 11/2012                    |
|                          | ROVIDER OR SUPPLIER<br>TRANSITIONAL CA                                                                       | RE & REHAB BIRCHWOOD TER                                                                                                                                  | 4                   | REET ADDRESS, CITY, STATE, ZIP (<br>13 STARR FARM RD<br>BURLINGTON, VT 05408                                                                                                                                                   | CODE .                                                                               |                            |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCY                                                                                             | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO TE<br>DEFICIENCY                                                                                                                                          | ON SHOULD BE<br>HE APPROPRIATE                                                       | (XS)<br>COMPLETION<br>DATE |
| F 356                    | Cantinued From pa                                                                                            | age 13                                                                                                                                                    | F 356               | This Plan of Carrection is the centeral allegation of compliance.                                                                                                                                                              | er's credible                                                                        |                            |
| į                        | a daily basis: o Facility name. o The current date o The total number                                        | ost the following information on a state of the actual hours worked tegories of licensed and                                                              |                     | Preparation and/or execution of the does not constitute admission or at provider of the truth of the facts all set forth in the statement of deficite correction is prepared and/or executi is required by the provisions of f | reement by the<br>leged or conclusions<br>ncies. The plan of<br>suted solely because | ·                          |
|                          | unfloensed nursing<br>resident care per s<br>- Registered nu<br>- Licensed pra                               | y staff directly responsible for<br>chift:<br>urses.<br>ctical nurses or licensed<br>(as defined under State law).<br>se aides.                           |                     | P 356  No residents were found to be the deficient practice.  No residents have the potent by the deficient practice.                                                                                                          |                                                                                      | May 11, 2012               |
|                          | specified above or of each shift. Data or Clear and reada                                                    | ost the nurse staffing data In a daily basis at the beginning a must be posted as follows: Ible format Stace readily accessible to                        | ·                   | The center will post a form total nursing hours and cens  Compliance will be monitor  monthly at the facility PI m                                                                                                             | na every day.                                                                        | · .                        |
|                          | residents and visit The facility must, make nurse staffit for review at a constandard. The facility must re- | upon oral or written request, and data available to the public at not to exceed the community maintain the posted dally nurse minimum of 18 months, or as |                     | months or until 100% comp<br>The administrator is respon<br>compliance.  F356 POC accepted 51 GColeman RN Amcoto                                                                                                               | oliance achieved.<br>sible for overall                                               |                            |
|                          | This REQUIREM by: Based on observing survey, the poster does not include                                     | ENT is not met as evidenced vations during the 3 days of d nursing staffing for the facility the total number of hours ed and unlicensed personnel,       |                     |                                                                                                                                                                                                                                |                                                                                      |                            |

Fax 6022412348

FPT 25No. 8753=7pm P. 18/24

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|-------|---------------------|
|       | PRINTED: 04/25/2012 |
|       | FORM APPROVED       |
|       | OMB NO. 0938-0381   |
|       |                     |

| CENTER                   | S EOR MEDICARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | & MEDICAID SERVICES                                                                                                                                                                  |                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                    | 0930-0321                  |
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| TATEMENT (               | OF DEFICIENCIES CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                | (X2) MULD           | TIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X3) DATE SU<br>COMPLE                                                             |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 475003                                                                                                                                                                               | B. WING             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 04/1                                                                               | 1/2012                     |
| NAME OF PR               | OVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                      | S                   | TREET ADDRESS, CITY, STATE, ZIP CO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | DOE                                                                                | ,                          |
| KINDRED                  | TRANSITIONAL CA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RE & REHAB BIRCHWOOD TER                                                                                                                                                             |                     | 43 STARR FARM RD<br>BURLINGTON, VT 05408                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                    |                            |
| (X4) ID<br>PREFIX<br>TAG | /EACH DEFICIENCS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | NTEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERÊNCED TO THI<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | N SHOULD BE<br>E APPROPRIATE                                                       | (X5)<br>COMPLETION<br>DATE |
| F 356                    | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                      | F 38                | anegation of compitance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                    |                            |
|                          | Specifics are as fold Per observation during staffing for the but does not the specific part of the specific part | iring the 3 days of survey, the<br>the day is posted in the facility<br>include the daily census nor                                                                                 |                     | Preparation and/or execution of the does not constitute admission or as provider of the truth of the facts all set forth in the statement of deficient correction is prepared and/or execution is required by the provisions of feet and the constitution of the provisions of feet and the provisions of the provisi | reement by the<br>eged or conclusions<br>acies. The plan of<br>used solely because | •                          |
| F9999                    | the total number of disciplines. This is                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | f hours worked by the Individual<br>s confirmed during interview<br>ministrator on 04/11/2012 at                                                                                     | F99                 | The process for delivering per timely meals and meaningful specific activities has been remeet the needs of the resider                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | l residents<br>evised to the                                                       | May 11, 201                |
|                          | Nursing Homes 7.13 Nursing Serv (d) Staffing Levels staffing levels add (1) At a minimum,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | s. The facility shall maintain<br>equate to met resident needs.<br>, nursing facilities must provide:<br>3 hours of direct care per                                                  |                     | The facility has advertised for in various local and New You An open house was held Ap The SDC and DNS are intercandidates for an LNA train scheduled to begin at or around.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | or open positions ork newspapers. ril 11, 2012. viewing ing program                |                            |
|                          | resident per day,<br>nursing care, persinursing care, but<br>supervision of sta<br>direct care, no fev                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | on a weekly average, including sonal care and restorative not including administration or ff; and of the three hours of wer than 2 hours per resident assigned to provide standard   |                     | The DNS and or designee is tracking and recruiting for the nursing department.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | responsible for<br>pen positions in                                                |                            |
|                          | LNA care (such a ambulation, feedi equivalent staff a preparation, phys                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | is personal care, assistance with<br>ng, etc.) performed by LNAs or<br>nd not including meal<br>sical therapy or the activities                                                      |                     | Open positions will reviewed PI committee meeting with recommendations ongoing.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | appropriate                                                                        |                            |
|                          | l program.  This REQUIREM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ENT is not met as evidenced by                                                                                                                                                       | :                   | The ED is responsible for o compliance.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                    |                            |
|                          | 1. In a review of with the Unit Mar Special Care Unithose 50 residen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | the residents during an interview<br>nager on 04/11/12, on Unit A (the<br>It) there are 50 residents. Of<br>ts, 6 residents require total care,<br>with eating, and require transfer |                     | F9999 PDC accepted<br>GColeman RN/ PME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5/10/12<br>CotaRN                                                                  |                            |
| EDBM CMS                 | total assistance \( \) -2567(02-99) Previous Vers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                      |                     | Facility ID: 475003                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | If continuation she                                                                | est Page 15 of             |

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| CENTER                   | S FOR MEDICAR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | E & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |                                                                  | OMB NO                                                               | . 0938-0391          |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------|----------------------------------------------------------------------|----------------------|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTI          | PLE CONSTRUCTION                                                 | (XS) DATE S<br>COMPLI                                                |                      |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 475003                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WING             |                                                                  |                                                                      | 1/2012               |
|                          | ROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | CARE & REHAB BIRCHWOOD TER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4                   | REET ADDRESS, CITY, STA<br>3 STARR FARM RD<br>BURLINGTON, VT 054 |                                                                      |                      |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG | (EACH CORRECT!) CROSS-REFERENCE                                  | AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY) | (%S) COMPLETION DATE |
|                          | total assistance vince of 1 or 2. An additional shifts comprised other straight 8 was adjusted. Ir day per resident shifts comprised other straight 8 was adjusted. Ir day per resident supplements of the per day per resident supplements of the supplements of th | page 15  14 residents raquire total care, with eating, and a transfer assist itional 10 residents require total ssistance or monitoring with ers. The remaining residents on a some level of assistance or me or all aspects of care and a stire unit census experience at some level. In summary, 30 total care for hygiene and residents require care and ording to the Unit Manager of 5 LNAs (Licensed Nursing ever there are frequent days call-ins or only 4 LNAs to care for urses may be pulled to caregiver at in providing direct care.  The provided schedule dated March of 29, 2012 there were 6 LNAs assigned on 5 days, and 2 LNA's assigned on 5 days, and 2 LNA's assigned on 5 days, except the 2nd, at of March, there were scheduled ranging in length of the scheduled ranging in length of t | F9999               |                                                                  |                                                                      |                      |
| FORM CHE                 | hours per reside                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u> </u>            | Facility 10; 478003                                              | If continuation she                                                  | :<br>et Page 16 of 1 |

787 4100, 8753 2188P. 20/24 PRINTED: 04/25/2012

| CENTERS FOR MEDICAL                                           | RE & MEDICAID SERVICES                                                                      |                                    |                                                                                         | OM6 NO. 0938-0391                |
|---------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------------------------------------------------------------|----------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           | (X1) PROVIDER/SUPPLIER/CLIA<br>(DENTIFICATION NUMBER)                                       | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION                                                                      | (X3) DATE SURVEY<br>COMPLETED    |
|                                                               | 475003                                                                                      | B. WING                            |                                                                                         | 04/11/2012                       |
| NAME OF PROVIDER OR SUPPLIE                                   | R<br>CARE & REHAB BIRCHWOOD TER                                                             | ļ                                  | TREET ADDRESS, CITY, STATE, ZIP COD<br>43 STARR FARM RD<br>BURLINGTON, VT 05408         | Ē                                |
| PREELY (FACH DEFICIE!                                         | STATEMENT OF DEFICIENCIES<br>NCY MUST BE PRECEDED BY FULL<br>R LSC (DENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE COMPLETION              |
| F9999 ' Continued From<br>the month of Ma<br>below 3 hours pe | page 18<br>rch was 3.31 with four days<br>er resident of direct care steff.                 | F999                               | 9                                                                                       | ;                                |
|                                                               |                                                                                             |                                    |                                                                                         |                                  |
|                                                               |                                                                                             |                                    |                                                                                         |                                  |
|                                                               |                                                                                             |                                    |                                                                                         |                                  |
|                                                               | rsions Ohspielo Event ID: 4NEK                                                              |                                    | Facility ID: 475003                                                                     | continuation sheet Page 17 of 17 |

|                  | TOF ISOLATED DEFICIENCIES WHICH CAUSE<br>TTH ONLY A POTENTIAL FOR MUMMAL HARM<br>TO NES                                                                                                                                                                                                                                                            | PROVIDER # 475003                                                                                                                                     | MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                                                                                                                                          | DATE SURVEY  COMPLETE: 4/11/2012                                 |
|------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
|                  | ovider or supplier<br>Transitional care & Rehab Birch                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY,<br>43 STARR FARM RI<br>BURLINGTON, VT                                                                                           | •                                                                                                                                                                                                    |                                                                  |
| o<br>Refix<br>ag | Summary Statement of Deficien                                                                                                                                                                                                                                                                                                                      | CIES                                                                                                                                                  |                                                                                                                                                                                                      |                                                                  |
| 7247             | 483.15(e)(2) RIGHT TO NOTICE BEFORE A resident has the right to receive notice                                                                                                                                                                                                                                                                     |                                                                                                                                                       |                                                                                                                                                                                                      | changod.                                                         |
|                  | This REQUIREMENT is not mot as evi Based upon interview and record review representatives before the resident's room.  Por record review and interview with the the record or on the facility "Notification were notified when the resident was moved. Also, per record review and interview with documentation in the record or on the facility." | the facility failed to pin was changed. (Reside<br>Social Worker on 4/1)<br>n of Room Change", the<br>red on 12/2/11 from a right the Social Worker o | nt #198) Finding includes:  /12 at 4:07 PM, there is no documn that Resident #198 and/ or the represorm on C-Wing to another room on 4/11/12 at 3:32 PM, there is no Room Change", that Resident #19 | entation in<br>sontative<br>n C-Wing.                            |
|                  | representative were notified when the rest the facility's "Notification of Room Chanotified, reason for room change, if the rThe facility's "Room to Room Transfer" of the transfer" and "Provide the transfer and introduce the patient to his/her new to                                                                                         | sident was moved on 3/ nge" documents when nove was voluntary; an procedure states "Notil ring patient with an op                                     | the resident or resident's represent<br>d is signed by the resident or repre<br>y the pationt and responsible party                                                                                  | n addition,<br>ative was<br>sentative.<br>In advance             |
|                  | the facility's "Notification of Room Cha<br>notified, reason for room change, if the r<br>The facility's "Room to Room Transfer"<br>of the transfer" and "Provide the transfer                                                                                                                                                                     | sident was moved on 3/ nge" documents when nove was voluntary; an procedure states "Notil ring patient with an op                                     | the resident or resident's represent<br>d is signed by the resident or repre<br>y the pationt and responsible party                                                                                  | n addition,<br>ative was<br>sentative.<br>In advance             |
|                  | the facility's "Notification of Room Cha<br>notified, reason for room change, if the r<br>The facility's "Room to Room Transfer"<br>of the transfer" and "Provide the transfer                                                                                                                                                                     | sident was moved on 3/ nge" documents when nove was voluntary; an procedure states "Notil ring patient with an op                                     | the resident or resident's represent<br>d is signed by the resident or repre<br>y the pationt and responsible party                                                                                  | n addition,<br>ative was<br>sentative.<br>in advance<br>the move |
|                  | the facility's "Notification of Room Chanotified, reason for room change, if the ranth facility's "Room to Room Transfer" of the transfer" and "Provide the transfer"                                                                                                                                                                              | sident was moved on 3/ nge" documents when nove was voluntary; an procedure states "Notil ring patient with an op                                     | the resident or resident's represent<br>d is signed by the resident or repre<br>fy the pationt and responsible party<br>portunity to tour the room prior to                                          | n addition,<br>ative was<br>sentative.<br>in advance<br>the move |

Any deficiency statement ending with an exterisk (1) denotes a deficiency which the institution they be excused from connecting providing it is determined that other take-marks provide sufficient protection to the patients. (See institutions.) Except for nursing himses, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date those documents are made available to the facility. If deficiencies are cited, we approved plan of

The above isolated deficiencies pose no notual harm to the residents